

TO DEPENDENT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Garrett</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Rural Kitzmiller</b><br>c. LENGTH OF STAY IN lb<br><b>30 yrs.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>4 Mi. N. Kitzmiller</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland.</b><br>b. COUNTY<br><b>Garrett</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Kitzmiller</b><br>d. STREET ADDRESS<br><b>4 Mi. N. Kitzmiller</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Wilbert Gordon Beeman</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>May 10th 19 61</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>July 3, 1913</b>     |
| 9. AGE (In years last birthday)<br><b>47 yrs.</b>   |                                  | IF UNDER 1 YEAR<br>Months Days<br><b>47</b>   | IF UNDER 24 HRS.<br>Hours Min.<br><b>47</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Coal Miner</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Soft Coal Mines</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Thomas Beeman</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Emma Stewart</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>213-05-4337</b>   |   |
| 17. INFORMANT<br><b>Mildred Beeman R. D. Kitzmiller, Md.</b>  |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>976X Maceration of brain secondary to gunshot wound of head</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>gunshot wound of head</b><br>(c) <b>Immediate</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Self inflicted .22 cal. rifle shot right temple</b> |                                  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Self inflicted .22 cal. rifle shot right temple</b>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>3:45</b> <b>5-10-61</b> p.m.  |                                  | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>   |                                  | 20f. (City or town) (County) (State)<br><b>Kitzmiller Rural Gar. Md.</b>  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                                  |   |   |
| ACTUAL SIGNATURE<br><b>James H. Feaster, Jr.</b>  |                                  | DATE SIGNED<br><b>May 13, 1961</b>  |   |
| EXAMINER'S NAME (Type)<br><b>James H. Feaster, Jr., M. D.</b>   |                                  | Address (Street, city, town, or county)<br><b>Oak., Md. 5-10-61</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>May 13, 1961</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>I.O.O.F. Cemetery</b>  |                                  | 22d. LOCATION (City, town, or country) (State)<br><b>Elk Garden, Mineral Co. W. Va.</b>   |   |
| 23. FUNERAL DIRECTOR<br><b>Amey M. Sharpless</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>Blaine, W. Va.</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Amey M. Sharpless</b>  |                                  | DATE<br><b>MAY 15 '61</b>   |   |

22

**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05631

5643

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|--|---|---|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Garrett</b> MARYLAND   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Oakland,</b>  |   |   |  | c. LENGTH OF STAY IN 1b<br><b>82 years</b>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>109 - 2nd Street</b>  |   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Horace</b> Middle <b>Leo</b> Last <b>Coddington</b>  |   |   |  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>18,</b> Year <b>1961</b>  |   |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 11, 1879</b>                             | 9. AGE (In years last birthday)<br><b>82 yrs.</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.             | IF UNDER 24 HRS.<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Carpenter</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Wood working</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Thomas Coddington</b>  |   |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Cecelia Jamison</b>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><b>232-24-0784</b>   |  | 17. INFORMANT<br><b>Mrs. Dora Coddington</b>  |   | Address<br><b>Oakland, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of prostate</b><br>177X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Enteritis desecosa</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>6 years</b><br><b>10 yrs</b> |   |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br><b>Oakland</b>                                | (County)<br><b>Md.</b>  | (State)   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10/3/1939</b> to <b>5/18/1961</b> that (I) (we) last saw the deceased alive on <b>5/17/1961</b> , and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above.  |   |   |  |   |   |  |  |
| 22a. SIGNATURE<br><b>Andrew E. Mance</b>   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>5/18/61</b>  |   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Andrew E. Mance, M. D.</b>  |   | 22d. ADDRESS<br><b>Oakland, Maryland.</b>   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>5/20/1961</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oakland Cemetery</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>Oakland, Md.</b> |   |   |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. E. Lighten</b>   |   | ADDRESS<br><b>Oakland, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAY 22 '61</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Thomas</b> |  |  |

(40)

CLINICAL EXAMINATION

2002

History of Present Illness: The patient is a 45-year-old male who has been experiencing intermittent episodes of dizziness and lightheadedness for the past several months. These symptoms are often exacerbated by standing up quickly or after meals. He has also noticed some mild fatigue and a general sense of well-being. There is no associated chest pain, shortness of breath, or palpitations. The symptoms have not been associated with any recent changes in diet, exercise, or stress levels. He has no history of similar symptoms in the past.

Physical Examination: The patient is well-developed and appears healthy. His vital signs are within normal limits. The heart, lungs, and abdomen are unremarkable. The neurological examination is normal, with no signs of focal deficits or cerebellar dysfunction. The otolaryngological examination is also normal.

Investigations: A complete blood count (CBC) and a comprehensive metabolic panel (CMP) were performed. The CBC is within normal limits, and the CMP shows no abnormalities. A 24-hour Holter monitor was worn for one week, and no significant arrhythmias were detected. A tilt table test was performed, and it revealed a positive result, consistent with a diagnosis of orthostatic hypotension.

Diagnosis: The patient's symptoms and the results of the investigations are consistent with a diagnosis of orthostatic hypotension. This condition is characterized by a drop in blood pressure upon standing, leading to the symptoms of dizziness and lightheadedness.

Management: The patient was advised to increase his fluid intake and to avoid standing up too quickly. He was also advised to avoid large meals and to eat smaller, more frequent meals. A low-salt diet was recommended. The patient was scheduled for a follow-up appointment in four weeks to reassess his symptoms and the effectiveness of the management plan.

# 1 FOR STATE HEALTH DEPT.

TO BE COMPLETED BY THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 5644 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05652

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|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Garrett</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>                 |  |  |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Swanton, Rural</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>73 yrs.</b>   |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>1 Mi. West Swanton, Md.</b>   |  |   |  | d. STREET ADDRESS<br><b>1 Mi. West Swanton</b>  |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>John Bunyan Friend, Sr.</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>18</b> , Year <b>1961</b>   |  |  |   |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Jan. 7, 1888</b>                                    |   |
| 9. AGE (in years last birthday)<br><b>73</b> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired employee County roads work</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                              |   |
| 13. FATHER'S NAME<br><b>John B. Friend</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Harriett Comp</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>no</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>220-10-1029</b>   |  |  |   |
| 17. INFORMANT<br><b>Weston Friend</b>  |  |   |  | Address<br><b>Swanton, Md.</b>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>420.1</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.<br>(b) <b>Arteriosclerosis</b><br>DUE TO<br>(c)  |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><br><b>Years.</b>                            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                               |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                       |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |  |   |
| ACTUAL SIGNATURE<br><i>James H. Feaster, Jr.</i>   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |   |
| EXAMINER'S NAME (Type)<br><b>James H. Feaster, Jr., M. D.</b>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |   |
| DATE SIGNED<br><b>5-18-61</b>  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>5/21/1961</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>George Cemetery</b>  |  | 22d. LOCATION (City, town, or country) (State)<br><b>near Swanton, Md.</b> |   |
| 23. FUNERAL DIRECTOR<br><i>Alton Leighton</i>  |  |   |  | ADDRESS<br><b>Oakland, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>MAY 22 '61</b>                               |   |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur L. Kline</i>  |  |  |   |

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FOR STATE  
HEALTH DEPT.  
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TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5645  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05633

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Garrett</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>                  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Oakland</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>32 Days</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Garrett County Memorial Hospital</b>   |  |   |  | d. STREET ADDRESS<br><b>Rural Deer Park</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Elsie Viola Gaster</b>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>May 10 19 61</b>   |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>11-23-02</b>                                      |  |
| 9. AGE (In years last birthday)<br><b>58</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days  |  | IF UNDER 24 HRS.<br>Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>             |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Benjamin Broadwater</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Rachel Wilt Broadwater</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>no</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  |  |  |
| 17. INFORMANT<br><b>"Husband" John Quincy Gaster, Deer Park, Md.</b>  |  |   |  | Address <b>Route # 2</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemopericardium, Cardiac Rupture</b><br>DUE TO (b) <b>Old Myocardial Infarction, Intramural thrombus, Pulmonary Embolism</b><br>DUE TO (c) <b>420.1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):  |  |   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                     |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 10, 1961</b><br>DATE SIGNED<br>Address (Street, city, town, or county) <b>Oakland, Maryland</b> |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>James H. Feaster, Jr.</i>  |  | M.D. <b>James H. Feaster, Jr. M.D.</b>  |  |   |  |  |  |
| EXAMINER'S NAME (Type)  |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>5/12/61</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Gaster Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Garrett Maryland</b> |  |
| 23. FUNERAL DIRECTOR<br>ADDRESS<br><b>Gerald N. Minnich</b><br><b>Oakland, Maryland</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>MAY 15 '61</b>  |  |  |  |
| 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. House</i>  |  |   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5646

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

65634

|  |                                  |  |                                    |
|--|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Garrett</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Oakland</b><br>c. LENGTH OF STAY IN 1b<br><b>9 Days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Garrett Co. Memorial Hospital</b>                                   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Garrett</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Rural Oakland</b><br>d. STREET ADDRESS<br><b>1 Route # 2 Box 88M</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Vinnie Loretta Glotfelty</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>May 17 1961</b>   |                                    |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>12-7-91</b> |
| 9. AGE (In years last birthday)<br><b>70</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>70</b>   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                    |
| 13. FATHER'S NAME<br><b>Lewis Kamp</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Spiker</b>  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |                                    |
| 17. INFORMANT<br><b>"Husband" Beason Glotfelty</b>   |                                  | Address <b>Route # Box 88M</b>   |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br>4 22... DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO (b) <b>Myocardial infarction</b><br>DUE TO (c) <b>Arteriosclerosis</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>17 hours</b><br><b>21 years</b><br><b>10 yrs</b>  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8-10-46</b> to <b>5-17-61</b> , that (I) (we) last saw the deceased alive on <b>5-17-61</b> , and that death occurred at <b>8:40 A.M.</b> from the causes and on the date stated above.   |                                  |  |                                    |
| 22a. SIGNATURE<br><b>Andrew E. Mance</b>   |                                  | 22b. DATE SIGNED<br><b>May 17 1961</b>   |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Andrew E. Mance, M. D.,</b>   |                                  | 22d. ADDRESS<br><b>Oakland, Maryland</b>   |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>5/19/61</b>  |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrett County Memorial Gardens</b>   |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Oakland, Maryland</b>  |                                    |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Gerald N. Minnich</b>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAY 22 '61</b>  |                                    |
| ADDRESS<br><b>Oakland, Maryland</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                    |

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

FOR STATE  
HEALTH DEPT.

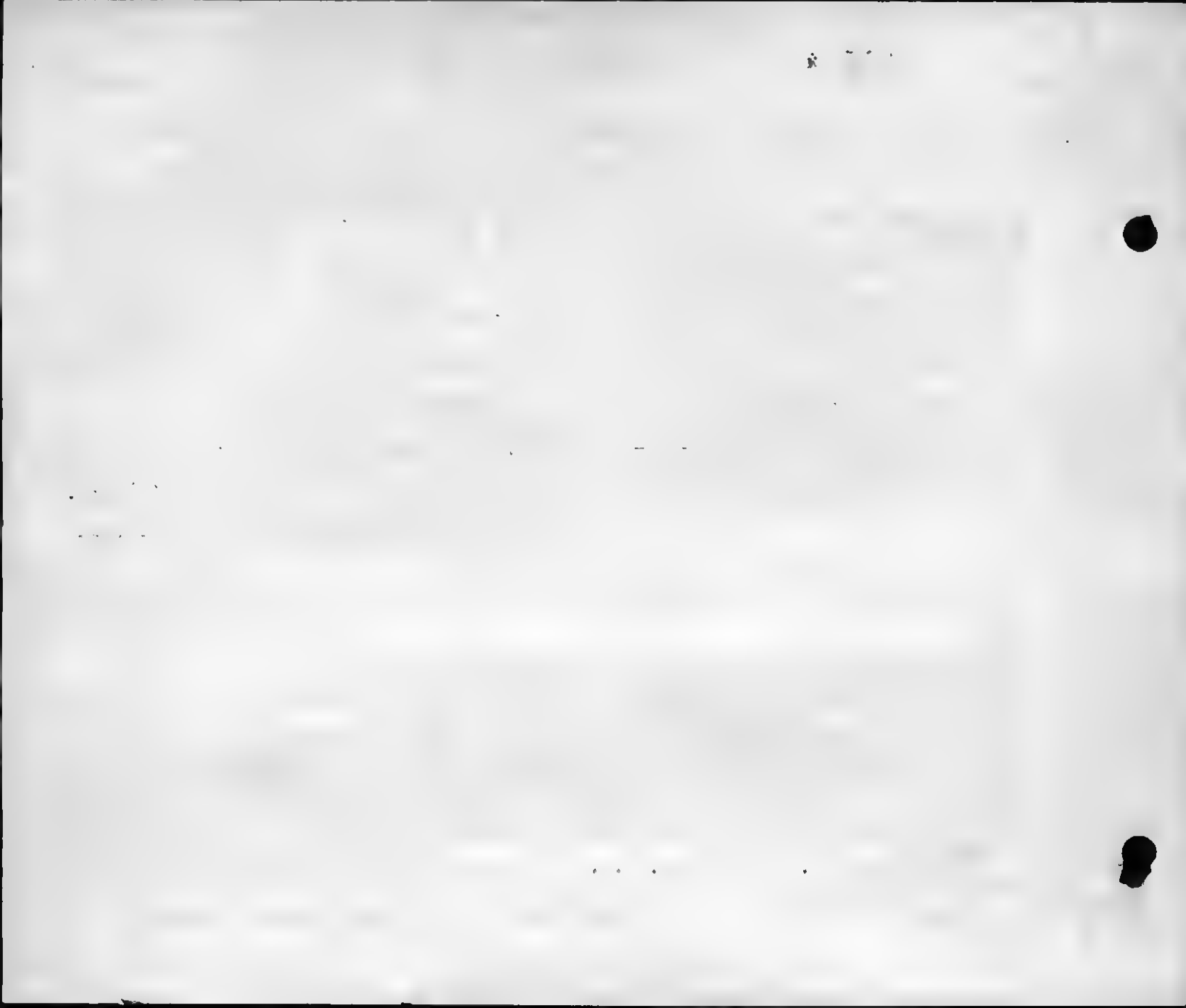
TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**5647 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Garrett</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Res. date before death on)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Oakland</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Oakland</b>  |  |
| c. LENGTH OF STAY IN lb<br><b>2 hours</b>   |  | d. STREET ADDRESS<br><b>4 th St.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Garrett County Memorial Hospital</b>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Kenneth Lees</b>   |  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>2</b> Year <b>1961</b>  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>Jan. 27, 1916</b>  |  |
| 9. AGE (In years last birthday) <b>45</b> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bookkeeping</b>                          |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Oakland, Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Arthur Lawton</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Bess Littman</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, (If yes give war or dates of service))<br><b>WW 2</b>   |  | 16. SOCIAL SECURITY NO.<br><b>214-07-3196</b>   |  |
| 17. INFORMANT<br><b>Mrs. Ann Lawton</b>   |  | Address<br><b>Oakland, Maryland</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>CORONARY OCCLUSION, LEFT</b><br>Concussions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS WITH THROMBOSIS</b><br>(c) <b>DUE TO</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.<br><b>INTERVAL BETWEEN ONSET AND DEATH 3-4 Hrs.</b> |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                    |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |   |  |
| ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M.D.</b>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>5/5/61</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Oakland, Maryland</b>  |  |
| 23. FUNERAL DIRECTOR <b>Gerald N. Minnich</b>   |  | 24a. REC'D BY REGISTRAR <b>MAY 5 '61</b>  |  |
|   |  | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinas</i>   |  |

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

Reg. Dist. No. 05636

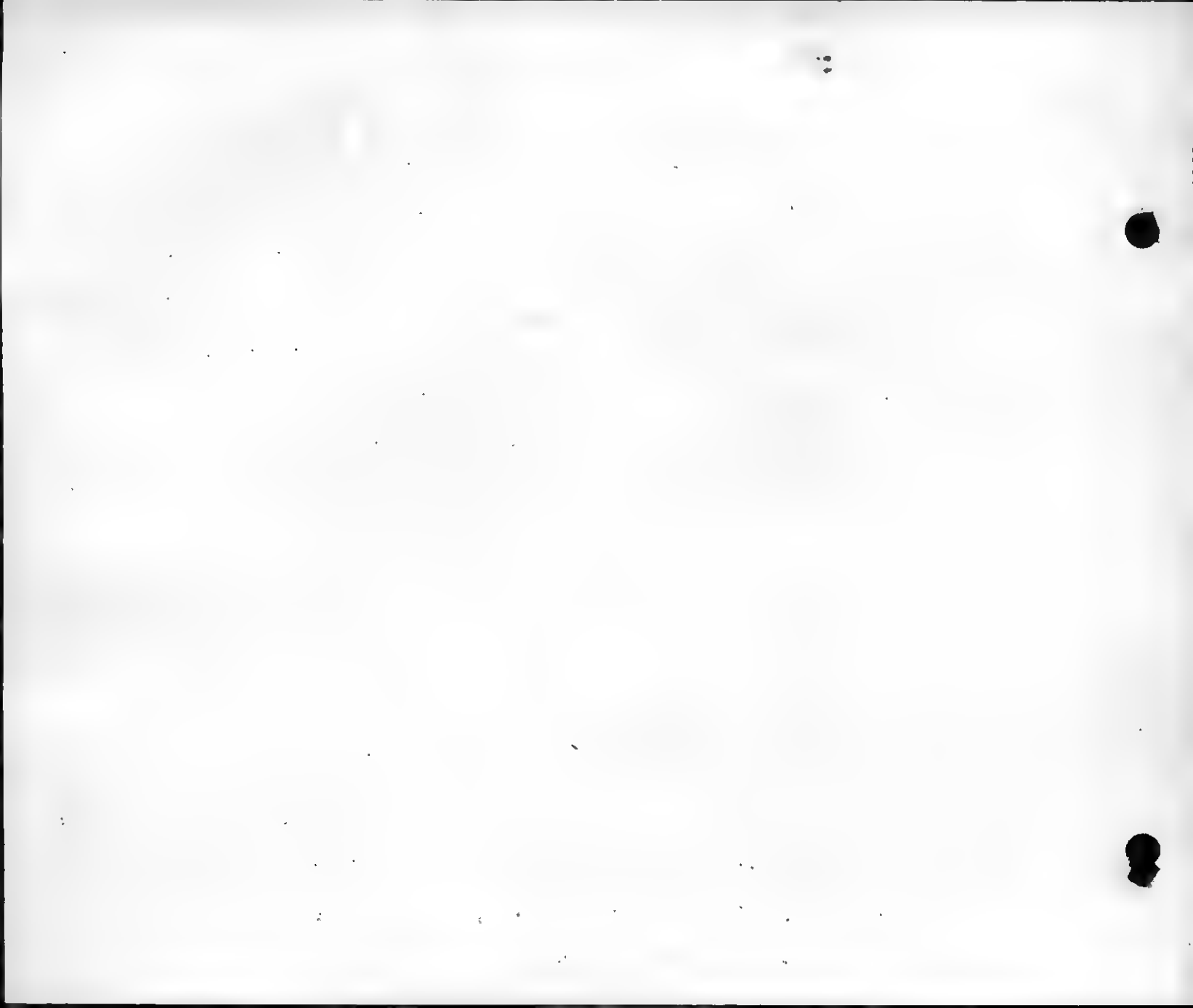
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|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Garrett</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission)<br>a. STATE <b>West Virginia</b> b. COUNTY <b>Preston</b>                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Oakland</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>89 days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Oak Rest Nursing Home</b>   |                                  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Terra Alta, W.Va. Route # 1,</b>  |   |
| f. STREET ADDRESS<br><b>Route # 1,</b>   |                                  | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>MALINDA</b> Middle <b>F..</b> Last <b>LEWIS</b>   |                                  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>20,</b> Year <b>1961.</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>            | 8. DATE OF BIRTH<br><b>March 20, 1878</b> |
| 9. AGE (In years last birthday)<br><b>83 yrs.</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>0</b> Hours <b></b> Min <b></b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Terra Alta, West Virginia</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>U. S. A.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   |
| 13. FATHER'S NAME<br><b>David H. Friend</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Abbigail Teets</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b> Address<br><b>Mrs. John W. Markwood, Terra Alta, W.Va.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lymphatic Leukemia</b><br><b>24.00</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO<br>(c) _____   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a m. _____ p. m. _____ 19 _____   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) _____ (County) _____ (State) _____   |   |
| 21. I certify that I attended the deceased from <b>May 13, 1961</b> to <b>May 20, 1961</b> that I last saw the deceased alive on <b>May 13, 1961</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED _____<br>ACTUAL SIGNATURE <b>Charles E. Smith</b> M.D. <b>Terra Alta, West Virginia 5/20/61</b><br>PHYSICIAN'S NAME (Type) <b>CHARLES E. SMITH, 216 East State Avenue, Terra Alta, W.Va.</b> |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal &amp; Burial 5/22/61</b>   |                                  | 22b. DATE THEREOF<br><b>5/22/61</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Grove Cemetery,</b>   |                                  | 22d. LOCATION (City, town, or county) _____ (State) _____<br><b>Route # 2, Terra Alta, W.Va.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>William E. D. License A8574</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>MAY 24 '61</b>   |   |
| ADDRESS<br><b>Terra Alta, W.Va.</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles E. Smith</b>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 05657

5649

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Garrett</u> MARYLAND   |                                  | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <u>West Virginia</u> b. COUNTY <u>Preston</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Oakland</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>1 yr 10 mos 24 ds</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Oak Rest Nursing Home</u>  |                                  | d. STREET ADDRESS<br><u>Main Street</u>   |   |
| 3 NAME OF DECEASED (Type or print)<br>First <u>Alberta</u> Middle <u>Jane</u> Last <u>May</u>   |                                  | 4. DATE OF DEATH<br>Month <u>May</u> Day <u>27</u> Year <u>1961</u>   |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>October 14, 1867</u> |
| 9. AGE (In years last birthday)<br><u>93</u> yrs.   |                                  | IF UNDER 1 YEAR<br>Months <u>7</u> Days <u>13</u><br>IF UNDER 24 HRS<br>Hours <u>  </u> Min. <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Fellowsville, West Virginia</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |   |
| 13. FATHER'S NAME<br><u>George E. Brown</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Sarah E. Danser</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO<br><u>None</u>   |   |
| INFORMANT<br><u>Mrs. Martha Eliason, Rowlesburg, W.Va.</u>  |                                  | Address   |   |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>4 <u>Anteroseptal Cardio Vascular Disease Unknown</u><br>DUE TO (b) <u>  </u><br>DUE TO (c) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |
| 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>May 30, 1960</u> to <u>May 27, 1961</u> , that I last saw the deceased alive on <u>May 22, 1961</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.  |                                  |   |   |
| ACTUAL SIGNATURE<br><u>Herbert H. Leighton</u>  |                                  | DATE SIGNED<br><u>77 Oak St. Oakland, Md. 31 May 61</u>   |   |
| PHYSICIAN'S NAME (Type)<br><u>Herbert H. Leighton, M.D.</u>   |                                  | <u>5th and Oak Streets, Oakland, Maryland.</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal &amp; Burial</u>  |                                  | 22b. DATE THEREOF<br><u>5/31/61</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Aurora Cemetery</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Aurora, West Virginia.</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Terra Alta, W.Va.</u>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <u>IN 5 '61</u>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><u>Edith S. Hume</u>  |                                  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



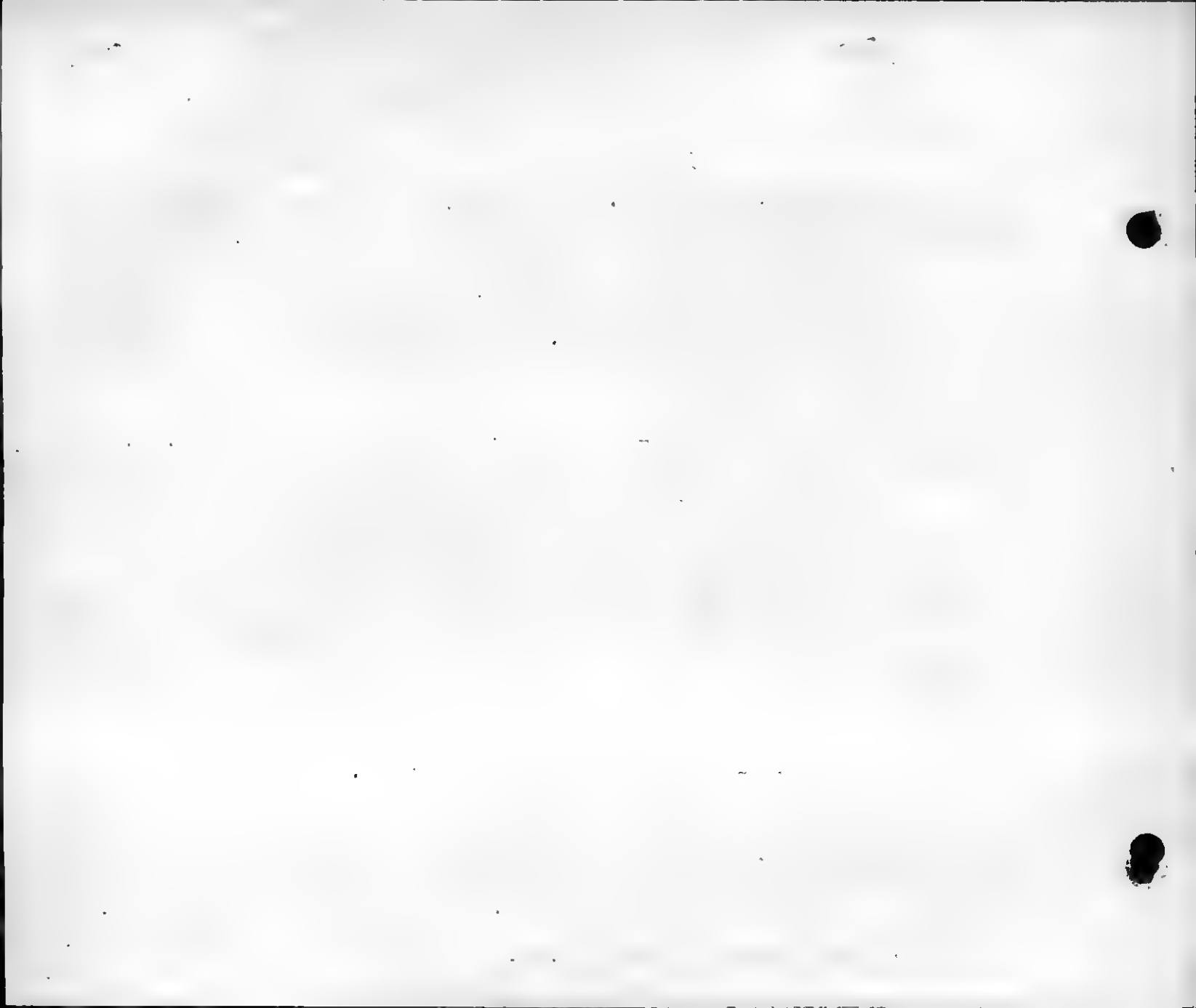
may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5650

05638

|   |                               |  |                                   |  |   |
|---|-------------------------------|--|-----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>GARRETT</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>  |                               | c. LENGTH OF STAY IN 1b <b>39 DAYS</b>   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>GARRETT</b> <b>Tucker</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>THOMAS, WEST VIRGINIA</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>  |                               | d. STREET ADDRESS <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>  |                                   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>EDWARD</b> Last <b>MILLER</b>   |                               | 4. DATE OF DEATH<br>Month <b>MAY</b> Day <b>12</b> Year <b>1961</b>  |                                   |  |   |
| 5. SEX <b>MALE</b>  | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>6/17/1886</b> | 9. AGE (In years last birthday) <b>74</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED MINER</b>   |                                   | 11. BIRTHPLACE (State or foreign country) <b>RED OAK, MARYLAND</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |                               | 13. FATHER'S NAME <b>DAN MILLER</b>  |                                   | 14. MOTHER'S MAIDEN NAME <b>ELIZA ARNOID</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |                               | 16. SOCIAL SECURITY NO. <b>232-09-0458</b>   |                                   | 17. INFORMANT Address <b>PAULINE GAITHER, BAYARD, W.VA.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>157X Carcinoma pancreas</b><br>DUE TO <b>Carcinomatosis to lungs &amp; liver</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>6 months</b><br>(c) |                               |  |                                   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                               |  |                                   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |                                   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   |
| 20f. (City or town) (County) (State)  |                               |  |                                   |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6-24</b> 19 <b>60</b> to <b>5-12-61</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5-12-61</b> 19 <b>61</b> , and that death occurred at <b>6:05 A.M.</b> from the causes and on the date stated above   |                               |  |                                   |  |   |
| 22a. SIGNATURE <b>Andrew S. Mance</b>   |                               | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                   |                                   | 22b. DATE SIGNED <b>13 May 61</b>  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>ANDREW E. MANCE</b>   |                               | 22d. ADDRESS <b>OAKLAND, MARYLAND</b>  |                                   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 23b. DATE THEREOF <b>May 14, 1961</b>  |                                   | 23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cem.</b>  |   |
| 23d. LOCATION (City, town or county) (State) <b>Garrett County, Md.</b>   |                               |  |                                   |  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Owens</b>   |                               | ADDRESS <b>Thomas, W.Va.</b>   |                                   | 25a. REC'D BY REGISTRAR DATE <b>MAY 17 '61</b>   |   |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Mance</b>   |                               |  |                                   |  |   |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5651

## CERTIFICATE OF DEATH

Reg. Dist. No.

05639

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Garrett</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mt. Lake Park</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>3 mos.</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>R St.</b>  |                                  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Gorman</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Dorsey Leo Moreland</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>May 15 19 61</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 9, 1882</b>  |
| 9. AGE (In years last birthday) yrs<br><b>78</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min<br><b>15 19 61</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>farming</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>near Gorman, Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>James Moreland</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Lish</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  |
| 17. INFORMANT<br><b>Mrs. Ina T. Moreland</b>  |                                  | Address<br><b>Gorman, Maryland</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bleeding ulcer</b><br>DUE TO <b>334X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Arteriosclerosis</b><br>(c) <b>Diabetes</b>   |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>3 years</b><br><b>10 years</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b><br><b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)</b><br><b>20c. TIME OF INJURY Month, Day, Year</b><br>Hour o. m. p. m. <b>19</b><br><b>20d. INJURY OCCURRED</b><br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/><br><b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b><br><b>20f. (City or town) (County) (State)</b> |                                  |   |  |
| 21. I certify that I attended the deceased from <b>1/10 1955</b> to <b>5/15 1961</b> , that I last saw the deceased alive on <b>5/11 1961</b> , and that death occurred at <b>5:20A M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>101 THIRD STREET</b> DATE SIGNED <b>10 May 61</b>  |                                  |   |  |
| ACTUAL SIGNATURE <b>A. E. Mance</b>   |                                  | PHYSICIAN'S NAME (Type) <b>A. E. MANCE</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |                                  | 22b. DATE THEREOF<br><b>5/17/61</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Grove Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Garrett Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Gerald D. Minnich</b>  |                                  | ADDRESS<br><b>Oakland, Maryland</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>May 22 '61</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>William S. King</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 2 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

5652

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05640

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Garrett</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oakland</b><br>c. LENGTH OF STAY IN 1b <b>50 yrs.</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. D. 2 Mi. S W Oakland,</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>Maryland.</b><br>b. COUNTY <b>Garrett</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oakland,</b><br>d. STREET ADDRESS <b>2 Mi. S W Oakland,</b><br>e. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF <b>Noah</b> First <b>Clinton</b> Middle <b>Slabaugh</b> Last<br>(Type or print)   |   | 4. DATE OF DEATH <b>May 17, 1961</b><br>Month Day Year  |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>Jan. 5, 1871</b><br>9. AGE (In years last birthday) <b>90</b> yrs                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>   | 11. BIRTHPLACE (State or foreign country) <b>Maryland.</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
| 13. FATHER'S NAME <b>Samuel Slabaugh</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Christina Durst</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b><br>(If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO. <b>---</b>  | 17. INFORMANT (Daughter) <b>Mrs. Elwood Beckman</b><br>Address <b>Oakland, Md.</b>                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>DUE TO <b>Chronic Pyelonephritis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Pyelonephritis</b><br>DUE TO (c) <b>Chronic Pyelonephritis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis Cardiovascular Disease.</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b><br><b>Unknown</b>                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>August 19, 59</b> to <b>May 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 17, 1961</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE <b>Herbert H. Leighton</b><br>22c. PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.</b>  |   | 22b. DATE SIGNED <b>17 May 61</b><br>22d. ADDRESS <b>Oakland, Md.</b>   |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>   | 23b. DATE THEREOF <b>5/20/1961</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Gortner Cemetery</b>  | 23d. LOCATION (City, town, or county) (State) <b>near Oakland, Md.</b>                                   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b><br>ADDRESS <b>Oakland, Md.</b>  |   | 25a. REC'D BY REGISTRAR DATE <b>MAY 22 '61</b>  | 25b. REGISTRAR'S SIGNATURE <b>Chas. S. Haines</b>  |



5635

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

05641

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Garrett</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Deer Park,</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>75 years</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sand Flat community</b>  |                                  | d. STREET ADDRESS<br><b>Sand Flat Community</b>   |   |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Harry</b> Middle <b>Franklin</b> Last <b>Speicher</b>   |                                  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>4</b> Year <b>1961</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 15, 1886</b>   |
| 9. AGE (In years last birthday)<br><b>75 yrs.</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Farmer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Farm</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>William H. Speicher</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Missouri Nine</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |                                  | 16. SOCIAL SECURITY NO. <b>215-14-6039</b>  |   |
| 17. INFORMANT<br><b>Harvey Speicher</b>   |                                  | Address<br><b>Star Route, Oakland, Md</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>terminal disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>terminal disease</b> DUE TO <b>terminal disease</b> (c) <b>terminal disease</b> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 years</b>                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>o. m.</b> <b>19</b> p. m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) and he deceased from <b>4/17</b> 19 <b>57</b> to <b>5/4</b> 19 <b>61</b> that (I) (we) lost saw the deceased alive on <b>5/11</b> 19 <b>61</b> and that death occurred at <b>10:30 A.</b> from the causes and on the date stated above.  |                                  |   |   |
| 22a. SIGNATURE<br><b>Andrew E. Mance</b>  |                                  | 22b. DATE SIGNED<br><b>5/11/61</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Andrew E. Mance, M. D.</b>   |                                  | 22d. ADDRESS<br><b>Oakland, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>5/6/1961</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Paradise Cemetery</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>dear Deer Park, Md.</b>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. C. Leighton</b>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAY 8 '61</b>  |   |
| ADDRESS<br><b>Oakland, Md.</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Orlando S. Frank</b>   |   |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

05642

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Garrett</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Oakland</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>43 yrs.</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Bertha</b> First <b>Wensel</b> Middle <b>Wensel</b> Last  |  |   |  | 4. DATE OF DEATH <b>May</b> Month <b>28</b> Day <b>19</b> Year <b>61</b>   |  |  |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>April 23, 1893</b>                                 |  |
| 9. AGE (In years last birthday) <b>68</b> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> |  | 11. BIRTHPLACE (State or foreign country) <b>Dobin, W. Va.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                |  |
| 13. FATHER'S NAME <b>Richard Nicholson</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Almira Roth</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |  |   |  | 16. SOCIAL SECURITY NO. <b>212-38-6278</b>   |  |  |  |
| 17. INFORMANT <b>Floyd L. Wensel</b>   |  |   |  | Address <b>Rural Oakland, Maryland</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary insufficiency.</b><br>DUE TO<br>(c) <b>Atherosclerosis</b> |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>20 mins</b><br><b>1 wk.</b>                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>      |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                   |  |
| 21. I certify that I attended the deceased from <b>23 May, 1961</b> , to <b>28 May, 1961</b> , that I last saw the deceased alive on <b>28 May, 1961</b> , and that death occurred at <b>1:15 AM</b> , from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Bowie Lynn Grant Mrs.</b>  |  |   |  | ADDRESS (Street, city or town, state) <b>Oakland, Md.</b>  |  | DATE SIGNED <b>31 May 61</b>   |  |
| PHYSICIAN'S NAME (Type)  |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>5/31/61</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Oakland, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Gerall N. Munnich</b>  |  |   |  | ADDRESS <b>Oakland, Maryland</b>   |  | 24a. REC'D BY REGISTRAR <b>JUN 6 '61</b>                               |  |
|  |  |   |  |  |  | 24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>                     |  |

TO HOSPITAL OR BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of birth: \_\_\_\_\_  
5. Place of birth: \_\_\_\_\_  
6. Date of death: \_\_\_\_\_  
7. Place of death: \_\_\_\_\_  
8. Cause of death: \_\_\_\_\_  
9. Signature of physician: \_\_\_\_\_  
10. Signature of registrar: \_\_\_\_\_  
11. Date of registration: \_\_\_\_\_

FILED  
JUL 15 1915  
NEW YORK

**TO THE MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Garrett</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Oakland</b><br>c. LENGTH OF STAY IN 1b<br><b>12 hours</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Garrett County Memorial Hospital</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>West Virginia</b><br>b. COUNTY<br><b>Preston</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Terra Alta</b><br>d. STREET ADDRESS<br><b>Route No. 2, Box 54</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>SANDRA JEANNETTE</b><br>First<br><b>WOLFE</b><br>Middle<br><b>WOLFE</b><br>Last  |  | 4. DATE OF DEATH<br><b>May</b><br>Month<br><b>1st</b><br>Day<br><b>1961</b><br>Year   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>July 11, 1956</b>  |  |
| 9. AGE (In years last birthday)<br><b>4</b><br>yrs.   |  | 10. IF UNDER 1 YEAR<br><b>9</b> Months <b>20</b> Days<br>11. IF UNDER 24 HRS.<br><b>12</b> Hours <b>12</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Kingwood, West Virginia</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>Elmer C. Wolfe</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Rosetta Maxine Liston</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>Elmer C. Wolfe, Terra Alta, W.Va.</b><br>Address  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADRENAL HEMORRHAGE;</b><br><b>053.2</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>FULMINATING SEPTISEMIA</b><br>(c) <b>PNEUMOCOCCUS</b>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 Hrs.</b><br><b>12 Hrs.</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE<br><i>James H. Feaster, Jr.</i><br>EXAMINER'S NAME (Type) <b>JAMES H. FEASTER, Jr. M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DATE SIGNED<br><b>MAY 1, 1961</b><br>Address (Street, city, town, or county) <b>Oakland, Md.</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal &amp; Burial</b>  |  | 22b. DATE THEREOF<br><b>5/3/61</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Terra Alta Cemetery</b>  |  | 22d. LOCATION (City, town, or country) (State)<br><b>Terra Alta, West Virginia.</b>   |  |
| 23. FUNERAL DIRECTOR<br><i>P. R. Watson</i><br><b>P. R. Watson, Md. F.D. License A 8574</b>   |  | 24a. REC'D BY REGISTRAR<br><b>MAY 4 '61</b><br>24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Hanna</i>   |  |

(M)

(1)

WEDNESDAY, JULY 11, 1951

11:00 AM

12:00 PM

1:00 PM

2:00 PM

3:00 PM

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